**Section 500.APPENDIX F Death Records**

**Section 500.ILLUSTRATION A Certificate of Fetal Death**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Type or Print in* |  |  |  |  |
| **PERMANENT INK** |  |  |
| *See Hospital and* | REGISTRATION DISTRICT NO | REGISTERED NUMBER | STATE OF ILLINOIS | STATE FILE NUMBER |
| *Funeral Directors* |
| *Handbooks for* | **CERTIFICATE OF FETAL DEATH** |  |
| *INSTRUCTIONS* |  |  |
|  | FETUS-*NAME* | FIRST  | MIDDLE | LAST | DATE OF DELIVERY (MONTH DAY YEAR) | HOUR |
|  | 1. | 2a. | 2b. | M |
| FETUS | SEX | COUTY OF DELIVERY | CITY, TOWN, TWP OR ROAD DISTRICT NO | HOSPITAL –*NAME* (IF NOT HOSPITAL GIVE STREET AND NUMBER) |
|  | 3. | 4a. | 4b. | 4c. |
|  | MOTHER-*MAIDEN NAME* | FIRST | MIDDLE  | LAST | DATE OF BIRTH (MONTH DAY YEAR) | BIRTHPLACE(STATE OR FOREIGN COUNTRY)5c. |
| MOTHER | 5a. | 5b. |
|  | RESIDENCE - STREET AND NUMBER OR RFD | CITY, TOWN, TWP OR ROAD DISTRICT NO | INSIDE CITY(YES NO) | COUNTY | STATE | ZIP CODE |
|  | 6a. | 6b. | 6c. | 6d. | 6e. | 6f. |
| FATHER | FATHER - *NAME* | FIRST | MIDDLE | LAST | DATE OF BIRTH (MONTH DAY YEAR) | BIRTHPALCE(STATE OR FOREIGN COUNTRY) |
|  | 7a. | 7b. | 7c. |
|  | INFORMANT'S SIGNATURE | RELATIONSHIP | MAILING ADDRESS (STREET AND NO. OR R.F.D. CITY OR TOWN, STATE AND ZIP) |
|  | 8a.► | 8b. | 8c. |
|  | 9. PART 1 FETAL DEATH WAS CAUSED BY | (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c)) | SPECIFY FETAL OR MATERNAL |
|  | FETAL OR MATERNALCONDITION DIRECTLYCAUSING FETAL DEATH |  | IMMEDIATE CAUSE |  |
|  | { |  |  |
|  | (a) |  |
|  |  | DUE TO OR AS A CONSEQUENCE OF |  |
|  | FETAL AND OR MATER-NAL CONDITIONS, IF ANY,GIVING RISE TO THEIMMEDIATE CAUSE (a),STATING THE UNDERLY-ING CAUSE LAST | { |  |  |
| CAUSE | (b) |  |
| DUE TO OR AS A CONSEQUENCE OF |  |
|  |  |  |
|  | (c) |  |
|  |  |  |
|  | PART II OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER CONTRIBUTING TO FETAL DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I | FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY UNKNOWN (SPECIFY) | AUTOPSY(YES NO) | WERE AUTOPSY FINDINGS AVAILALE PRIOR TO COMPLETION OF CAUSE OF DEATH? (YES NO) |
|  |  | 10. | 11a. | 11b. |
|  | I CERTIFY THAT THIS FETUS WAS BORN DEAD AT THE PLACE AND TIME ON THE DATE STATED ABOVE | DATE SIGNED (MONTH DAY YEAR) | ATTENDANT – M.D., D.O., MIDWIFE, OTHER (SPECIFY) |
|  | *SIGNATURE* |  |  |
| CERTIFIER | 12a. ► | 12b. | 12c. |
| CERTIFIER'S COMPLETE MAILING ADDRESS (STREET AND NO OR R.F.D., CITY OR TOWN, STATE, ZIP) | ILLINOIS LICENSE NUMBER |
|  | 12d. | 13. |
|  | BURIAL, CREMATION, OR REMOVAL | CEMETERY OR CREMATORY – *NAME* | LOCATION (CITY OR TOWN, STATE) | DATE (MONTH DAY YEAR) |
|  | (SPECIFY) |  |  |  |
|  | 14a. | 14b. | 14c. | 14d. |
|  | FUNERAL HOME | NAME | STREET AND NUMBER OR R.F.D. | CITY OR TOWN | STATE | ZIP |
|  | 15a. |
| DISPOSITION | FUNERAL DIRECTOR'S SIGNATURE | FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER |
| 15b. | 15c. |
|  | LOCAL REGISTRARS SIGNATURE | DATE FILED BY LOCAL REGISTAR (MONTH, DAY, YEAR) |
|  | 16a. ► | 16b. |

**Section 500.APPENDIX F Death Records**

**Section 500.ILLUSTRATION A Certificate of Fetal Death (Continued)**

|  |  |  |  |
| --- | --- | --- | --- |
| VR-110-(11/89) |  | INFORMATION FOR HEALTH AND STATISTICAL USE ONLY | (BASED ON 1989 U.S. STANDARD CERTIFICATE) |
|  | OF HISPANIC ORGIN? |  | RACE-American Indian, | 19. EDUCATION | 20. OCCUPATION AND BUSINESS/INDUSTRY |
|  | (Specify below No or Yes-If Yesspecify Cuban, Mexican, Puerto Rican, etc.) |  | Black, White, etc. | (Specify only highest grade completed) | (Worked during last year) |
|  |  |  | (Specify below) | Elementary/Secondary (0-12) | College (1-4 or 5+) | Occupation | Business/Industry |
| 17. |  | 18. |  |  |  |  |  |
|  | [ ]  | No | [ ]  | Yes |  |  |  |  |  |  |
| MOTHER | 17a. | Specify: | 18a. |  | 19a. |  | 20a. | 20b. |
|  | [ ]  | No | [ ]  | Yes |  |  |  |  |  |  |
| FATHER | 17b. | Specify: | 18b. |  | 19b. |  | 20c. | 20d. |
| 21. PREGNANCY HISTORY(Complete each section)MULTIPLE BIRTHSEnter State File Number for Mate(s)LIVE BIRTH(S) FETAL DEATH(S) | MOTHER MARRIED? at delivery, conception or at  | DATE LAST NORMAL MENSES BEGAN |
|  | any time between (Yes or No) | (Month, Day, Year) |
|  | 22. | 23. |
| LIVE BIRTHS | OTHER TERMINATIONS(Spontaneous and induced atany time after conception) | MONTH OF PREGNANCY PRENATAL CARE BEGAN | PRENATAL VISTS |
|  |  | First, Second, Third, Etc. (Specify) | Total Number (if none so state) |
|  |  | 24. | 25. |
| NOW LIVING | NOW DEAD | (Do Not Include This Fetus) | WEIGHT OF FETUS | CLINICAL ESTIMATE OF GESTATION |
| Number  | Number  | Number  | (Specify Units) |  |
| 21a. [ ]  None | 21b. [ ]  None | 21d. [ ]  None | 26. | 27. | Weeks |
| DATE OF LAST LIVE BIRTH | DATE OF LAST OTHER TERMINATION | PLURALITY | IF NOT SINGLE BIRTH - Born |
| (Month, Year) | (Month, Year) | Single, Twin, Triplet, etc. (Specify) | First, Second, Third, etc. (Specify) |
| 21c. | 21e. | 28a. | 28b. |
| DATE OF MOTHER'S BLOOD TEST FOR SYPHILIS (Month Day Year) | LABORATORY DOING THE SEROLOGY |
|  | 29a. | 29b. |
| 30a.Printed by the Authority of the State of IllinoisIllinois Department of Public Health – Division of Vital Records | MEDICAL RISK FACTORS FOR THIS PREGNANCY(Check all that apply) | 32. | OBSTETRIC PROCEDURES(Check all that apply) | 34. | CONGENITAL ANOMALIES OFFETUS (Check all that apply) |
|  |  |  |  |  |  |
| Anemia (Hct.<30/Hgb. <10)  | 01 | [ ]  | Amniocentesis  | 01 | [ ]  | Anencephalus  | 01 | [ ]  |
| Cardiac disease  | 02 | [ ]  |  |  | Electronic fetal monitoring  | 02 | [ ]  |  |  | Spina bifida/Meningocele  | 02 | [ ]  |  |  |
| Acute or chronic lung disease  | 03 | [ ]  | Induction of labor  | 03 | [ ]  | Hydrocephalus  | 03 | [ ]  |
| Diabetes  | 04 | [ ]  |  |  | Stimulation of labor  | 04 | [ ]  |  |  | Microcephalus  | 04 | [ ]  |  |  |
| Genital herpes  | 05 | [ ]  | Tocolysis  | 05 | [ ]  | Other central nervous system anomalies |  |  |
| Hydramnios/Oligohydramnios  | 06 | [ ]  |  |  | Ultrasound  | 06 | [ ]  |  |  | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 05 | [ ]  |
| Hemoglobinopathy  | 07 | [ ]  | None  | 00 | [ ]  | Heart malformations  | 06 | [ ]  |  |  |
| Hypertension, chronic  | 08 | [ ]  |  |  | Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 07 | [ ]  |  |  | Other circulatory/respiratory anomalies |  |  |
| Hypertension, pregnancy associated  | 09 | [ ]  |  | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 07 | [ ]  |
| Eclampsia  | 10 | [ ]  |  |  | 33. COMPLICATIONS OF LABOR | Rectal atresia/stenosis  | 08 | [ ]  |  |  |
| Incompetent cervix  | 11 | [ ]  | AND/OR DELIVERY (Check all that apply) |  |  | Tracheo-esophageal fistula/ |  |  |  |  |
| Previous infant 4000 + grams  | 12 | [ ]  |  |  | Febrile (>100°F. or 38°C.)  | 01 | [ ]  | Esophageal atresia  | 09 | [ ]  |
| Previous preterm or small-for-gestational-age infant  | 13 | [ ]  | Meconium, moderate, heavy  | 02 | [ ]  |  |  | Omphalocele/Gastroschisis  | 10 | [ ]  |  |  |
| Renal disease  | 14 | [ ]  |  |  | Premature rupture of membrane (>12 hours) |  | 03 | [ ]  | Other gastrointestinal anomalies |  |  |  |  |
| Rh sensitization  | 15 | [ ]  | Abruptio placenta  | 04 | [ ]  |  |  | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 11 | [ ]  |
| Uterine bleeding  | 16 | [ ]  |  |  | Placenta previa  | 05 | [ ]  | Malformed genitalia  | 12 | [ ]  |  |  |
| None  | 00 | [ ]  | Other excessive bleeding  | 06 | [ ]  |  |  | Renal agenesis  | 13 | [ ]  |
| Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 17 | [ ]  |  |  | Seizures during labor  | 07 | [ ]  | Other urogenital anomalies |  |  |  |  |
|  |  |  |  |  | Precipitous labor (<3hours)  | 08 | [ ]  |  |  | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 14 | [ ]  |  |  |
| 30b. OTHER RISK FACTORS FOR THIS |  |  |  |  | Prolonged labor (>20 hours)  | 09 | [ ]  | Cleft lip/palate  | 15 | [ ]  |
| PREGNANCY (Complete all items) |  |  |  |  | Dysfunctional labor  | 10 | [ ]  |  |  | Polydactyly/Syndactyly/Adactyly  | 16 | [ ]  |  |  |
| Tobacco use during pregnancy  | Yes | [ ]  | No | [ ]  | Breech/Malpresentation  | 11 | [ ]  | Club foot  | 17 | [ ]  |
| Average number of cigarettes per day \_\_\_ |  |  |  |  | Cephalopelvic disproportion  | 12 | [ ]  |  |  | Diaphragmatic hernia  | 18 | [ ]  |  |  |
| Alcohol use during pregnancy  | Yes | [ ]  | No | [ ]  | Cord prolapse  | 13 | [ ]  | Other musculoskeletal/integumental anomalies |  |
| Average number drinks per week \_\_\_\_\_ |  |  |  |  | Anesthetic complications  | 14 | [ ]  |  |  | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 19 | [ ]  |
| Weight gain during pregnancy \_\_\_\_\_ lbs. |  |  |  |  | Fetal Distress  | 15 | [ ]  | Down's syndrome  | 20 | [ ]  |  |  |
|  |  |  |  |  | None  | 00 | [ ]  |  |  | Other chromosomal anomalies |  |  |  |  |
| 31. METHOD OF DELIVERY (Check all that apply) | Other (specify)  | 16 | [ ]  | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 21 | [ ]  |
|  |  |  |  |  |  | SOCIAL SECURITY NUMBER | None  | 00 | [ ]  |  |  |
| Vaginal  | 01 | [ ]  | MOTHER |  |  |  | Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 22 | [ ]  |
| Vaginal birth after previous C-section  | 02 | [ ]  |  |  |  | 35. |  |  |  |  |
| Primary C-section  | 03 | [ ]  |  | SOCIAL SECURITY NUMBER |  |  |  |  |  |  |
| Repeat C-section  | 04 | [ ]  |  |  | FATHER |  |  |  |  |  |  |  |  |  |  |
| Forceps  | 05 | [ ]  |  | 36. |  |  |  |
| Vacuum  | 06 | [ ]  |  |  |  |  |  |  |  |  |
| Hysterotomy/Hysterectomy  | 07 | [ ]  |  |  |  |  |  |  |  |  |

(Source: Added at 15 Ill. Reg. 11706, effective August 1, 1991)